

WELCOME TO TUFTS HEALTH PLAN

Please complete all of the member sections of the membership application in full. Failure to do so could delay enrollment. You must be a Massachusetts resident to enroll in any of these plans.

Member Sections

Personal Information - Complete all enrollment information. If your plan requires the selection of a primary care physician (HMO) please be sure to fill out this section for all members, including dependents.

If you have problems finding a primary care physician, you can visit our Web site, www.tuftshealthplan.com/enrollnow.

Dependents - Dependents claimed on your federal income tax are eligible for enrollment on your family plan for two years following their loss of IRS code dependent status or until their 26th birthday, whichever comes first. You may be required to submit proof of dependent status. Please be sure to fill out all appropriate information for each dependent, including primary care physician (if applicable).

Other Health Coverage - If you have other insurance (including Medicare) please check the correct box and fill in the additional information about your other insurance. If you do not have other insurance, be sure to check the "no" box.

When the application is complete,

PLEASE RETURN THIS FORM TO:

Tufts Health Plan
554 Main Street
P.O. Box 15014
Worcester, MA 01615-0014

Member Please Note:

By enrolling, you agree to and understand that if you or any of your enrolled dependents (a) obtain a health care benefit or payment that you know you are not entitled to receive or be paid; or (b) knowingly present or cause to be presented, with fraudulent intent, information on this application, or a claim that contains a false statement, you may be liable for the full amount of the health care benefit or payment made and for reasonable attorney's fees and costs, including cost of investigation. In addition, we may terminate your coverage.

Tufts Health Plan arranges for the provision of health care services, but does not provide health care services. Tufts Health Plan arranges for the provision of health care through agreements with independent community-based health care professionals working in private offices and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents, or representatives of Tufts Health Plan for any purposes.

Need Help?

If you need assistance filling out this form, our member services specialists are here to help.
1-800-957-6596

You can also log onto our Web site at www.tuftshealthplan.com/enrollnow for more information.

MEMBER ENROLLMENT FORM

Please print or type. Please be sure application is completed in full to ensure enrollment.

No one does more to keep you healthy.

FAILURE TO COMPLETE THE UNDERLINED SECTIONS MAY CAUSE A DELAY IN ENROLLMENT.

CHOOSE PLAN TYPE	
<input type="checkbox"/> HMO Value Choice Copay	<input type="checkbox"/> HMO Select 15
<input type="checkbox"/> PPO Value	<input type="checkbox"/> HMO Select 20
<input type="checkbox"/> Advantage HMO 1000	<input type="checkbox"/> Advantage HMO Select 750
	<input type="checkbox"/> Advantage HMO Select 2000

Member Section	<input type="checkbox"/> New Enrollee or	<input type="checkbox"/> Qualifying Event for Changes to Plan (MUST specify) _____	Qualifying Event Date _____	Requested Effective Date of Coverage _____
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1. <u>E-mail</u>		2. Have you or anyone in your family used tobacco products, e.g., cigarettes, chewing tobacco, etc., in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. <u>Last Name</u>		4. <u>First Name</u>		5. <u>Middle Initial</u>
6. <u>Social Security Number (SSN)</u>				
7. <u>Mailing Address</u> (Home Address)	8. <u>Apt#</u>	9. <u>City</u>	10. <u>State</u>	11. <u>ZIP</u>
12. <u>Gender</u> <input type="checkbox"/> M <input type="checkbox"/> F		13. <u>Date of Birth</u> / / month day year		
14. <u>Marital Status</u> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		15. <u>Type of Coverage Requested</u> <input type="checkbox"/> Individual <input type="checkbox"/> Subscriber/Spouse <input type="checkbox"/> Subscriber/Child or Children <input type="checkbox"/> Family		
16. <u>Primary Care Physician</u>		17. <u>PCP ID#</u>		18. Check if currently used for primary care <input type="checkbox"/>
19. <u>Home Telephone</u> ()		20. <u>Work Telephone</u> ()		21. <u>Fitness Center</u>
22. <u>Primary Language</u>				

<u>Members Enrolling</u> (Last name, if different)	<u>Sex</u> M/F	<u>Date of Birth</u>	If dependent is over age 19, please check one		<u>Social Security Number</u>	<u>Fitness Center</u>	DO NOT WRITE IN THIS SPACE	<u>Choose a Primary Care Physician for each member</u>	<u>Tufts Health Plan Affiliated Hospital</u>	<u>Check if currently used for primary care</u>	<u>PCP ID#</u>
			Full-time Student	Disabled							
23. <u>Spouse</u>					- -						
24. <u>Child/Dependent</u>					- -						
25. <u>Child/Dependent</u>					- -						
26. <u>Child/Dependent</u>					- -						
27. <u>Child/Dependent</u>					- -						
28. <u>Child/Dependent</u>					- -						
29. <u>Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect?</u> <input type="checkbox"/> Yes <input type="checkbox"/> Yes (Medicare) <input type="checkbox"/> No		<u>Name of Health Plan</u>		<u>Name of Plan Holder</u>		<u>Health Plan Number</u>		<u>Effective Date</u>		<u>Names of Family Members Covered</u>	
30. Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Name and Address of Employee									
31. Please check If you are using additional membership applications for additional dependent children <input type="checkbox"/>											

The information supplied on this form is true and complete. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payment directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (or we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the member services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.

Signature (required): _____

Date: _____